KENTUCKY DEPARTMENT OF WORKERS' CLAIMS
Frankfort, Kentucky 40601

REQUEST FOR INFORMATION

It is the responsibility of each self-insured employer to provide the Department of Workers' Claims with accurate, up-to-date information for our records. The Self Insurance Branch is to be informed of any change in the administration of the self-insured employer's Workers' compensation program, including contact names, telephone numbers, third party administrators, and self-administered policies.

To the Department of Workers' Claims: _____, 20 _____

Applicant:

Company Name: _____

Self-Insurance Inception Date: _____

Federal Employer ID Number: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____

Contact Name: _____

Phone: _____ Fax: _____

Email: _____

Administration of Self-Insurance Program:

Is the administration of the self-insurance program handled in-house?

☐ Yes ☐ No

If the administration of the self-insurance program is handled by a Third Party Administrator, please provide the following information:

Company Name: _____

Address: _____

Contact Name: _____

Phone: _____ Fax: _____

Email: _____

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Claims Administration:

Is the administration of claims handled in-house?

☐ Yes ☐ No

If No, you **must** list the current and all previous Third Party Administrators in chronological order for the entire self-insurance period.

Current Company

Inception Date: _____

Company Name: _____

Address: _____

Contact Name: _____

Phone: _____ Fax: _____

Email: _____

Former Company

Inception Date: _____ End Date: _____

Company Name: _____

Address: _____

Contact Name: _____

Phone: _____ Fax: _____

Email: _____

If additional pages are needed in order to list all former TPA's, please utilize the format above.

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Subsidiary/Division/Location Information:

Please list all **entities (including all subsidiaries and divisions)** doing business within the Commonwealth of Kentucky that are to be included under the self-insurance program. Divisions should be listed under the appropriate corporate name. The corresponding address of each work location is to be included.

Please Note:

Self-Insurers Guarantee Agreement (Form SI-01) must be on file for each subsidiary listed. If there is **no** Guarantee Agreement on file, the subsidiary **will not** be listed as being covered under the self-insurance program.

It is the **responsibility of the self-insured employer to notify the Self-Insurance Branch of any and all changes** involving the subsidiaries, divisions, and work locations located within the Commonwealth of Kentucky. Written notification should be forwarded to The Department of Workers' Claims Self-Insurance Branch at the earliest opportunity indicating any locations to be added to or deleted from the self-insurance program as well as any changes in name or address of work locations.

Subsidiary:

Name: _____ FEIN: _____

Address: _____

Division: 1. _____
(Name and Address)

Locations: A. _____
(Name and Address)

Division: 2. _____
(Name and Address)

Location: A. _____
(Name and Address)

If additional pages are needed in order to list all entities to be included, please utilize the format above.

Please ensure that this 'Request for Information' page is completed in its entirety in order for the Self-Insurance Certification process to be completed.

It is the policy of the Department of Workers' Claims Self-Insurance Branch for this information to be provided **each year** as part of the recertification process. This information is essential in maintaining complete and accurate records on all Self-Insured employers.

Please Note:

The self-insured employer is responsible for notifying the Department of Workers' Claims Self-Insurance Branch, in writing, of **any changes** to this information which occur at any time during the approved period of self- insurance.